Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Medical Center of Lewisville

Respondent Name
TX Public School WC Project

MFDR Tracking Number
M4-14-1077-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 5, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Authorization was obtained prior to services being rendered. However, all lines denied stating auth # missing, invalid or does not apply to billed services or provider. Also states billed ICD9 codes do not match ICD9 codes on Preauth. Please review for authorization denial."

Amount in Dispute: $8,859.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Initially, a review of the preauthorization letter in this claim supports the determination that none of the diagnoses billed by Requestor were preauthorized. Therefore, an extent of injury dispute exists in this claim as the ICD-9 codes billed by Requestor are inconsistent with the compensable injury accepted by the Respondent, which is limited to right knee anterior cruciate ligament sprain and right knee medical meniscus tear."

Response Submitted by: Creative Risk Funding, 6100 W Plano Parkway, Ste 1500, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10 -11, 2012	29888	$8,859.00	$8,859.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out requirements of prior authorization of specific medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 15 – The authorization number is missing, invalid, or does not apply to the billed service or provider
- -Notes: Billed ICD9 codes Do not match ICD 9 codes on Preauth.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 18 – Duplicate claim/service

Issues

1. Did the requestor obtain prior authorization for services in dispute?
2. Did the requestor appropriately raise issues of compensability or extent?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 15 – "The authorization number is missing, invalid, or does not apply to the billed service or provider. Review of the submitted documentation named, "Pre-Authorization Determination Letter" amended, 12/10/2012. CPT code 29888 (Arthroscopic ACL) was Pre-Authorized with number 52003. Review of the medical bill created March 13, 2013 finds this authorization number listed in Section 53(A). As the procedure in dispute (29888) was prior authorized, the carrier's denial is not supported. This service will be reviewed per applicable fees and guidelines.
2. In its response to medical fee dispute resolution, the carrier states, in pertinent part, that "this treatment was not administered for the compensable injuries." According to 28 Texas Administrative Code §133.240(e), (e)(2)(C), the carrier is required to issue an explanation of benefits in the form and manner prescribed by the Division to the health care provider and the injured employee when denying payment due to "(C)unrelated to the compensable injury, in accordance with §124.2 and 124.3 of this title." Although the carrier mentions compensability and extent in its response to Notification of Medical Fee Dispute Resolution, as discussed in paragraph one, no documentation was found to support that the carrier issued the electronic or paper explanation of benefits that contained all the elements required by §133.240(e). The Division concludes that the carrier did not meet the requirements of 28 Texas Administrative Code §133.240
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J2271, date of service December 10, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J3010, date of service December 10, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1713, date of service December 10, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415, date of service December 10, 2012, has a status indicator of A, which denotes

services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75.

- Procedure code 85014, date of service December 10, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.35. 125% of this amount is $4.19
- Procedure code 76000, date of service December 10, 2012, has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 29888 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
- Procedure code 73560, date of service December 10, 2012, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.84. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.90. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of $26.03. The non-labor related portion is 40% of the APC rate or $17.94. The sum of the labor and non-labor related amounts is $43.97. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $43.97. This amount multiplied by 200% yields a MAR of $87.94. This service does not have with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; therefore per 28 Texas Administrative Code 134.60(p)(8)(A) does not require prior authorization.
- Procedure code 27332, date of service December 10, 2012, cannot be recommended for reimbursement. Review of the submitted DWC 60 finds this service is not included in request for medical fee dispute resolution.
- Procedure code 29888, date of service December 10, 2012, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0052, which, per OPPS Addendum A, has a payment rate of $6,212.62. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,727.57. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of $3,606.42. The non-labor related portion is 40% of the APC rate or $2,485.05. The sum of the labor and non-labor related amounts is $6,091.47. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.148. This ratio multiplied by the billed charge of $8,859.00 yields a cost of $1,311.13. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $6,091.47 divided by the sum of all APC payments is 99.28%. The sum of all packaged costs is $7,976.11. The allocated portion of packaged costs is $7,918.95. This amount added to the service cost yields a total cost of $9,230.08. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $6,091.47. This amount multiplied by 200% yields a MAR of $12,182.94.
- Procedure code 97116, date of service December 11, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the

highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2012 is $26.00. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $37.02. Per 28 Texas Administrative Code 134.60(p)(5)(C) details prior authorization for physician therapy services is required "except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (ii) a surgical intervention previously preauthorized by the insurance carrier;…" The carrier's denial is not supported.

- Procedure code 97110, date of service December 11, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2012 is $29.25. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $41.65. Per 28 Texas Administrative Code 134.60(p)(5)(C) details prior authorization for physician therapy services is required "except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (ii) a surgical intervention previously preauthorized by the insurance carrier;…" The carrier's denial is not supported.
- Procedure code 97001, date of service December 11, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2012 is $70.47. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $113.58. Per 28 Texas Administrative Code 134.60(p)(5)(C) details prior authorization for physician therapy services is required "except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (ii) a surgical intervention previously preauthorized by the insurance carrier;…" The carrier's denial is not supported.
- Procedure code J2405, date of service December 11, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005 is unbundled. Per Medicare policy, payment for this service is included in the payment for other services billed on the same claim. Separate payment is not recommended.

5. The total allowable reimbursement for the services in dispute is $12,471.07. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $8,859.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $8,859.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $8,859.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 1, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.